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VENEREAL DISEASES IN ENGLAND AND WALES*

EXTRACT FROM THE ANNUAL REPORT OF THE CHIEF MEDICAL OFFICER FOR THE YEAR 1967

During the past 10 to 15 years it has been a recurring theme in reports from those concerned with community health that, whereas other infectious diseases have proved increasingly susceptible to control, the venereal diseases, or some of them, have increased almost everywhere and have resisted the most diligent efforts to provide a lasting solution to the problem. Nevertheless, the Report for 1966 gave some reason for encouragement because the returns from the clinics of England and Wales showed an appreciable decline in infectious syphilis, which of the major venereal diseases is the one most susceptible to control, and no more than a moderate increase in gonorrhoea. In respect of the latter, the figures for the past few years suggested that the curve of increase was flattening at what was, however, a new high level for peace time.

It is satisfactory to note that the returns for 1967 show a further decline in cases of infectious syphilis, indicating that the spread of this disease, which has proved so intractable in other countries, is being contained here. On the other hand, as will appear from the details which follow, gonorrhoea has shown a further sharp increase in both men and women and the prospects for an early solution to this problem seem remote.

Syphilis

It has been customary for the past few years to define infectious syphilis in two ways. The first which has been used for many years includes all infections believed to have been acquired within the year preceding the first attendances of the patients and comprises all cases in the primary and secondary stages and those of early latent infection. This definition has the disadvantage that the duration of latent infection is often a matter of guesswork but it is retained to permit direct comparison with the past. Figures are also given under a second definition which restricts these cases to those of primary and secondary syphilis only. In 1966 there were 1,819 cases of primary, secondary, and early latent syphilis reported from the clinics, of which 1,431 were in males and 388 in females, showing a decline of 14 per cent. in 1966 over 1965 and giving a male–female ratio of 3·7:1, as compared with 4·5:1 in 1965. The corresponding total of cases for 1967 was 1,732, of which 1,378 were in males and 354 in females, a reduction of 4·8 per cent. as compared with 1966 and giving a male–female ratio of 3·8:1. Using the second and probably more accurate definition, there were 1,374 cases of primary and secondary syphilis in 1966, of which 1,132 were in males and 242 in females. The equivalent total for 1967 was 1,321, of which 1,075 were in males and 246 in females giving a reduction of 3·8 per cent. in 1967 over 1966 and a male–female ratio of 4·4:1 as compared with 4·7:1.

The figures are small by any standards and it is difficult to draw from them reliable conclusions other than the obvious one that control measures have proved successful within limits. The fact that the reduction in primary and secondary cases has occurred only in men may reflect the increasing diligence with which sources of infection are being traced and brought under treatment, but there have also been changes in the pattern of immigration which could have had an effect.

The numbers of cases of primary and secondary and early latent syphilis reported from ten urban areas in 1966 and 1967 are shown in Table I. Cases from the inner London area, always the major source of infection, declined from 897 in 1966 to 784 in 1967. Both sexes showed appreciable reductions, cases in men diminishing from 749 to 679 and those in women from 148 to 105. On Merseyside, on the other hand, there was a considerable increase

*Report of the Ministry of Health for the year ended December 31, 1967, p. 65, and Appendix C, p. 279. H.M.S.O., London.

TABLE I

EARLY SYPHILITIC INFECTIONS DEALT WITH FOR THE FIRST TIME IN TEN SAMPLE AREAS
1966–1967

Urban Areas	1966			1967		
	Males	Females	Totals	Males	Females	Totals
Inner London* (3,118,630)	749	148	897	679	105	784
Merseyside (Liverpool, Bootle, Birkenhead and Wallasey) (1,032,620)	97	32	129	136	62	198
Manchester and Salford (759,950)	13	7	20	34	5	39
Tyneside (Newcastle, S. Shields and Tynemouth) (431,850)	16	7	23	10	2	12
Hull, Kingston-upon (295,900)	16	—	16	8	2	10
Southampton (209,790)	21	3	24	25	1	26
Bristol (429,020)	22	2	24	27	1	28
Birmingham (1,101,990)	52	29	81	34	25	59
Leeds and Bradford (804,640)	32	10	42	26	11	37
Sheffield (534,100)	3	1	4	5	2	7

*The inner London Boroughs and the City of London.
Figures in brackets denote estimated populations at June 30, 1967.

in cases in both men and women, the former rising from 97 to 136, the latter from 32 to 62, and the total, therefore, from 129 to 198. Increases of varying degree were also recorded at Manchester and Salford, at Southampton, at Bristol, and at Sheffield. Cases decreased on Tyneside, at Kingston-upon-Hull, at Birmingham, and at Leeds and Bradford.

Table II indicates the numbers of cases in which syphilis, seen in the primary and secondary stages, was believed to have been contracted in England and Wales or abroad. It is, of course, common for a disease such as syphilis to be contracted while in another country, by a seaman for instance, and, because of the long incubation period, to present no sign until the patient has returned home. With some promiscuous individuals it is impossible to determine the source of infection and thus to say where the disease was acquired. In 1967, 15·1 per cent. of these infections were known to have been contracted abroad, as compared with 19·7 per cent. in 1966.

TABLE II

INFECTIONS CONTRACTED AT HOME AND ABROAD

Infection contracted	Syphilis		Gonorrhoea	
	Number	Per cent.	Number	Per cent.
In the United Kingdom	1,028	77.8	38,436	92.1
Abroad	199	15.1	1,726	4.1
Not known	94	7.1	1,560	3.7

Information obtained from the clinics regarding the ages of patients suffering from primary and secondary syphilis is shown in Table VI. It relates to 1,298 of the reported total of 1,321 cases. Of 1,051 infections in males 91 (8·6 per cent.) (p. 71) affected patients under the age of 20 years, and of 247 in females 44 (18 per cent.) affected patients of this age. The equivalent percentages for 1966 were 6·8 and 21, so that there is little evidence of change.

The Cooperative Clinical Group of the Medical Society for the Study of Venereal Diseases has continued its yearly assessment of the relative incidence of primary and secondary syphilis among those who were born in this country and those from other countries. Details were collected from 169 clinics in England and Wales relating to 1,229 cases, of which 996 were in men and 233 in women, comprising 92·3 per cent. of the officially reported cases in men and 94·7 per cent. of those in women. Of the men, 60·9 per cent. were born in the United Kingdom, as compared with 50·3 per cent. in 1966; 10·1 per cent. were born in Asia, 9·3 per cent. in the West Indies, 8·1 per cent. in the Continent of Europe, 3·5 per cent. in Eire, and 3·2 per cent. in Mediterranean countries. Smaller numbers came from other countries. Of the women, 87·6 per cent. were born in the United Kingdom, 3·0 per cent. in the West Indies, 2·6 per cent. in Asia, 1·7 per cent. in Mediterranean countries, and 1·3 per cent in Eire. Smaller numbers were born in other countries. It should again be explained that the figures relating to those born abroad do not give any reliable indication of the extent to which this disease is contracted by immigrants. Some of the patients concerned are visitors and, particularly, foreign seamen for whom services are provided under the Brussels agreement.

In the Annual Report attention has been drawn repeatedly to the great importance of persuading

patients to give information whenever possible concerning the likely sources of their infections and also concerning those to whom they may have transmitted infection. In attempting to secure the attendance of these "contacts" various methods are used and very often the patients themselves act as helpful intermediaries. How essential prompt action of this kind is in preventing spread of infection is well illustrated by the occurrence of an outbreak of infectious syphilis among the staff of a holiday camp in the South of England during the summer of 1967. The staff were mainly young people recruited for domestic duties during the holiday season. Prompt action by the venereologist to whom the first infected patient presented resulted in the discovery of no less than ten patients with infectious syphilis. There were six other known contacts; three of these remained under observation for 4 months and were proved free from infection, but three others disappeared and at least one is known to have attended a clinic in London and to have been suffering from infectious syphilis. An outbreak of this kind may appear small and unimportant but it can lead to an alarming spread of disease if infected contacts are not traced and treated. Fortunately this particular episode evidently occurred within a temporarily closed circle and prompt and diligent action was able to limit what might have been a serious epidemic.

During 1967 it was possible to take action regarding the contacts of 693 of the 1,075 men who were found to be suffering from primary and secondary syphilis and of 173 of the 246 infected women. As the result of these measures 94 infected men and 87 infected women were brought under treatment. These numbers may appear small but they represent considerable and devoted efforts in a task which involves much difficulty and frustration. The fact of rendering non-infectious 181 individuals who otherwise might not have sought advice was an important contribution to the public health. Apart from these cases there are instances in which details are given about contacts residing abroad. This information is passed to the Ministry of Health from which the necessary action is taken to inform the appropriate medical authorities in the countries of residence.

Cases of late syphilis show for the first time for years a moderate increase over the numbers for the preceding year. The details are shown in Table III. The difficulty of interpreting these figures was discussed in the Report for 1966. In the present instance it can be seen that the reported severe manifestations of late syphilis, namely those involving the cardiovascular and nervous systems, decreased in number and that the increase was limited to cases of late latent syphilis. In such cases blood tests are positive but there are no other signs of the disease. An increase of this kind could result from a more general application of routine serological testing, from improved standards in techniques of serological tests, or from the difficulty of distinguishing between latent syphilis and non-venereal treponemal diseases, such as yaws, in immigrants from countries where these closely related diseases are endemic. In 1966 it was noted that positive serological tests thought to be due to old yaws or other non-venereal treponematoses were found in 979 cases. The equivalent figure for 1967 was lower, namely 903, but the decision as to the cause of such positive tests is often a matter of guesswork.

TABLE III

INCIDENCE OF LATE SYPHILIS, BY SEX

Late Syphilis	Year	Males	Females	Total
Cardiovascular syphilis	1966	99	54	153
	1967	95	41	136
Neurosyphilis	1966	173	82	255
	1967	156	69	225
All other late or latent stages	1966	659	530	1,189
	1967	714	580	1,294
Total. Late or latent stages	1966	931	666	1,597
	1967	965	690	1,655

Figures from the Registrar General's Annual Statistical Review show year by year the numbers of deaths reported from the major destructive effects of syphilis, namely general paralysis of the insane, tabes dorsalis, and syphilitic aneurysm of the aorta. Results over the years are shown in the Appendix, Table E. During 1967 deaths from general paralysis continued to show a satisfactory decline in both sexes and the numbers reported are now very small. Deaths from tabes dorsalis have declined in men but increased a little in women. Deaths from aortic aneurysm have shown some increase in both sexes.

Congenital syphilis remains a small problem but one which should constantly remind us of the possible results of any relaxation in the highly effective methods taken to prevent it. Appendix Table C shows in detail the numbers of reported cases over the last 18 years. Cases identified in infants in the first year of life amounted to fifteen in 1967 as compared with twelve in 1966. Those identified in older children, that is the "missed cases" of earlier years, amounted to 201 in 1967 as

compared with 250 in 1966. The death rate per 1,000 live births of infants under one year certified as due to congenital syphilis amounted to 0·001, a figure which has remained unchanged during the past 4 years (Appendix Table D).

Testing for Syphilis in Pregnancy The results of blood tests for syphilis on those groups of the population to which these tests are regularly applied, such as pregnant women, enable some estimate to be made of the prevalence of latent undiagnosed treponemal disease in various communities. Table IV shows the results of tests reported in 1967 from six regional blood transfusion centres at which routine tests are performed for the regions concerned.

Table IV shows that the proportion of these patients with positive tests is very low indeed and Table V, which summarizes the results at these centres during the past 14 years, shows that the proportion has declined consistently during the past five years.

TABLE V

RESULTS OF SEROLOGICAL TESTS IN PREGNANT WOMEN, 1954–1967

Year	Primiparae		Multiparae	
	Number	Percentage Positive	Number	Percentage Positive
1954	39,181	0.23	47,941	0.32
1955	41,392	0.21	40,712	0.43
1956	48,420	0.28	40,295	0.35
1957	49,914	0.14	43,730	0.29
1958	49,315	0.13	40,765	0.23
1959	56,962	0.14	46,531	0.16
1960	61,606	0.08	46,349	0.14
1961	67,294	0.13	49,583	0.27
1962	61,872	0.11	48,435	0.19
1963	68,347	0.16	57,774	0.22
1964	69,412	0.12	61,362	0.20
1965	72,623	0.10	61,287	0.13
1966	69,662	0.07	59,043	0.11
1967	70,859	0 05	58,782	0.08

Gonorrhoea

The difficulties and the reasons for relative lack of success in controlling the spread of this disease have been discussed in successive Reports during the past few years. However, in 1966, it was possible to say that the numbers of cases, which had risen consistently from 1954 to 1961, had after that time shown only minor variations and seemed to have stabilized at a new high level. Unfortunately the figures for 1967 again show a marked increase and hopes for a breathing space for concentrating on some of the fundamental problems concerned with the spread of this infection have been disappointed. In 1966 the cases reported from the clinics amounted to 37,483, an increase of 2 per cent. over 1965. The increase was more marked in women than in men and it was thought that this might have been due to greater efficiency in methods of contact tracing. The total of cases reported in 1967 was 41,829, an increase of 11·6 per cent. over 1966 and the highest number reported from the clinics since the post-war peak year of 1946. Cases in adult men rose from 27,913 in 1966 to 30,630 in 1967; those in adult women from 9,465 to 11,081. The male–female ratio was approximately 2·8, as compared with 2·9 in 1966. The figures suggest that in spite of difficulties contact tracing is being pursued diligently and that in consequence many infected women, who because of lack of symptoms might remain sources of infection, are being brought under treatment.

The total of 41,829 cases includes 77 of vulvovaginitis in children, which is seven more than last year, and 41 cases of gonorrhoeal ophthalmia in the newlyborn, as compared with 35 in 1966. Returns from the clinics showed that the 41,711 infections acquired by patients past the age of puberty involved 37,849 individuals, indicating that multiple infections still add considerably to the total cases in the course of any one year.

TABLE IV

SYPHILIS TESTS IN PREGNANCY, 1967

Centre	No. of Ante-natal Patients			Positive Syphilis Tests					
				Primiparae		Multiparae		Parity not Known	
	Primiparae	Multiparae	Parity not Known	No.	Per cent.	No.	Per cent.	No.	Per cent.
Cambridge	10,250	8,765	599	13	0.127	16	0.183	8	1.336
Leeds	12,607	7,010	1,070	3	0.024	7	0.099	—	—
Liverpool	18,622	22,806	—	8	0.042	14	0.061	—	—
Oxford	3,769	3,574	1,106	1	0.027	2	0.056	—	—
Plymouth	2,314	2,499	—	4	0.173	3	0.120	—	—
Sheffield	23,297	14,128	—	8	0.034	10	0.071	—	—

Doubtful, Plymouth: primiparae 14, multiparae 6.

The ages of patients suffering from gonorrhoea are shown in Table VI. Of the patients who acquired gonorrhoea in sexual intercourse, 15 per cent. were under the age of 20 years, as compared with 14 per cent. in 1966. 179 girls and 36 boys under the age of 16 years presented with infection as compared with 160 girls and 52 boys in 1966. The number of girls aged 16 to 19 was 2,850, as compared with 2,299 in 1966, and the number of boys was 2,653 as compared with 2,311 in 1966. In the age group of 19 years and under, the girls outnumbered the boys, amounting to 3,029 as compared with 2,689 boys. In general the pattern of distribution in these younger age groups is similar to that of recent years, the increases in numbers being no more than was to be expected with the increase in total cases.

The Cooperative Clinical Group conducted a further study into the countries of origin of patients suffering from gonorrhoea. Details were collected from 169 clinics in England and Wales relating to 38,066 cases, or 91 per cent. of the total officially reported in the Annual Returns. Of 27,979 men suffering from gonorrhoea, 56·4 per cent. were born in the United Kingdom as compared with 54·6 per cent. in the similar study for 1966; 17·3 per cent. were born in the West Indies, 7·5 per cent. in Asia, 5·2 per cent. in Eire, 4·4 per cent. in Mediterranean countries and 4·0 per cent. in Europe, with smaller numbers from other countries. Of 10,087 females, 82·1 per cent. were born in the United Kingdom, as compared with 82·4 per cent. in 1966; 6·9 per cent. in the West Indies, and 4·1 per cent. in Eire, with smaller numbers from other areas.

At the clinics "contact slips" were issued to 22,225 patients suffering from gonorrhoea, of whom 19,235 were men and 2,990 were women. As the result of this and other measures the attendance was secured of 6,671 infected contacts, of whom 1,227 were men and 5,444 women. These figures compare with 815 men and 4,711 women in 1966 and they certainly seem to indicate that diligence in this important epidemiological procedure is not only being maintained but extended.

Prostitutes in Holloway Prison

The number of prostitutes admitted to H.M. Prison, Holloway, during 1967 was 516, as compared with 419 in the preceding year. The number of their admissions also increased from 740 to 866. Of the 516, 478 submitted to examination and of these one was found to be suffering from primary syphilis, six from secondary syphilis, and 91 from gonorrhoea. Five of the latter were treated for the disease on more than one occasion. Of 102 prostitutes aged between 15 and 20 years, 61 submitted to examination and tests. Three of these were suffering from infectious syphilis and 35 from gonorrhoea.

Other Venereal Diseases

Cases of non-gonococcal urethritis in men were first reported in a separate category in 1951 and since then the numbers of reported cases have increased every year. 1967 was no exception, the cases amounting to 32,318 as compared with 30,462 in 1966. 357 of these were complicated by arthritis, as compared with 327 in 1966. The corresponding condition in women is not a clear-cut clinical entity and is included among "other conditions requiring treatment within the centre", the number of which in females increased from 25,102 in 1966 to 28,417 in 1967.

The other venereal diseases seldom flourish in our temperate climate and the small numbers which occur are usually imported from tropical and sub-tropical countries. There were 64 cases of chancroid, as compared with 83 in 1966, 58 cases of lymphogranuloma venereum as compared with 41, and one case of granuloma inguinale as compared with three in the preceding year.

Other Conditions seen at the Clinics

Details are shown in Appendix Table A. In 1967 there were 53,754 cases of other conditions requiring

TABLE VI

AGES OF PATIENTS SUFFERING FROM EARLY SYPHILIS AND GONORRHOEA, BY SEX

Age (yrs)	Primary and Secondary Syphilis				Gonorrhoea			
	Males	Females	Total	Per cent.	Males	Females	Total	Per cent.
Under 16	2	2	4	0.3	36	179	215	0.6
16 and 17	20	16	36	2.8	555	975	1,530	4.0
18 and 19	69	26	95	7.3	2,098	1,875	3,973	10.5
20 to 24	220	74	294	22.7	8,528	3,647	12,175	32.2
24 and Over	740	129	869	66.9	16,320	3,636	19,956	52.7
Totals	1,051	247	1,298	100.0	27,537	10,312	37,849	100.0

treatment, as compared with 47,697 in 1966, and 44,706 cases of other conditions requiring no treatment at the clinics, as compared with 45,360 in 1966.

Although there have been many immigrants from areas where yaws is endemic, there have been few reports of cases of active infectious manifestations of this disease. It is noteworthy, therefore, that three such cases were reported from a clinic in an industrial city in the Midlands during 1966, and two more, with probably a third, from the same clinic during 1967.

The Present Position

The evidence of the past year seems to justify the conclusion that syphilis could be controlled even though extramarital sexual intercourse is clearly regarded by many as a normal and permissible activity. But the small reduction reported does not amount to control. The description given of a limited outbreak of this disease in a holiday camp in the South of England carries a sharp warning of the possible effects of any relaxation of vigilance. Unfortunately, gonorrhoea, a more infectious disease with a short incubation period, which so often gives rise to no symptoms in women, is much more difficult to control. Without a change in public attitude there seems small hope of diminishing the incidence unless some major advance in prophylaxis or treatment occurs, neither of which seems in prospect at present. The indication is to intensify all the methods at present available, especially that of contact tracing. Non-gonococcal urethritis remains an intractable problem. The cause of it is unknown and the evidence that it is a transmissible infection is therefore based on epidemiological experience. But the evidence is very strong. The outcome of treatment is uncertain in some cases and some of these patients are prone to relapse. In some cases there are serious complications, early and late, mainly involving the joints and eyes. Further advances in diagnosis and treatment await the discovery of a causative organism or organisms, and this is proving a difficult problem. In the meantime, the number of cases reported from the clinics continues to increase and possibly indicates only a fraction of the true total. It seems likely that modern methods of contraception, which provide no element of mechanical protection, favour the spread of gonorrhoea and non-gonococcal infection.

The question of instructing the young, as part of health education, is one which is exercising the minds of the educational authorities and more is being done. The importance of this is beyond question, but it is an uphill task because so much depends upon family background, the example of others and the behaviour of the group. The results of a campaign of this kind will be difficult or impossible to assess, but the fact remains that young people are entitled to accurate helpful information on this, as on other matters, and it should not be withheld from them. No doubt the new Health Education Council, which has taken over the responsibilities of the Central Council for Health Education, will play its full part in keeping the public informed on matters relating to the venereal diseases and their prevention.

TABLE A

NUMBER OF CASES (IN ALL STAGES) DEALT WITH FOR THE FIRST TIME AT ANY CENTRE*, 1950–67

Sex	Year	Syphilis	Soft Chancre	Gonorrhoea	Non-gonococcal Urethritis (males only)	Other Conditions		Total columns 2–6
							Not requiring treatment	
Male	1950	5,979	433	17,007	—	55,068		78,487
	1951	4,506	437	14,975	10,794	11,607	26,956	69,275
	1952	3,760	389	15,510	11,552	12,578	25,928	69,717
	1953	3,272	347	15,242	13,157	13,566	25,619	71,203
	1954	2,929	301	13,962	13,279	13,071	24,651	68,193
	1955	2,711	285	14,079	14,269	13,613	24,436	69,393
	1956	2,778	307	16,377	14,825	14,254	23,514	72,055
	1957	2,747	254	19,620	16,066	14,332	23,032	76,051
	1958	2,947	247	22,398	17,606	14,562	21,711	79,021
	1959	2,252	265	24,964	20,227	15,241	23,160	86,109
	1960	2,401	226	26,618	22,004	17,393	26,087	94,729
	1961	2,730	227	29,519	24,472	18,562	27,567	103,077
	1962	2,496	154	28,329	24,494	19,244	25,217	99,934
	1963	2,371	153	27,895	25,289	19,925	28,373	104,006
	1964	2,507	135	29,050	27,521	19,520	29,436	108,169
	1965	2,811	66	27,886	29,141	21,399	30,324	111,627
	1966	2,454	80	27,921	30,462	22,595	29,414	112,926
	1967	2,434	63	30,645	32,318	25,337	28,748	119,545
							Not requiring treatment	
Female	1950	4,988	17	3,497	—	23,840		32,342
	1951	3,926	16	3,089	—	8,517	12,408	27,956
	1952	3,362	14	3,585	—	8,916	11,560	27,437
	1953	2,914	9	4,021	—	9,834	10,612	27,390
	1954	2,352	8	3,574	—	10,117	9,503	25,554
	1955	2,272	10	3,766	—	10,182	9,075	25,305
	1956	2,363	9	4,011	—	10,939	8,835	26,157
	1957	2,230	6	4,761	—	11,317	9,098	27,412
	1958	1,829	12	5,489	—	12,149	9,001	28,480
	1959	1,675	2	6,380	—	12,752	9,554	30,353
	1960	1,545	5	7,152	—	15,199	10,876	34,777
	1961	1,712	1	7,588	—	16,861	12,122	38,284
	1962	1,624	3	7,109	—	16,973	12,567	38,276
	1963	1,510	6	8,154	—	19,206	13,685	42,561
	1964	1,268	5	8,615	—	20,602	14,062	44,552
	1965	1,264	5	8,805	—	22,842	14,485	47,401
	1966	1,224	3	9,562	—	25,102	15,946	51,837
	1967	1,169	1	11,184	—	28,417	15,958	56,829

* Excludes cases transferred from centre to centre.

TABLE B

CASES OF ACQUIRED SYPHILIS IN TABLE A WITH INFECTIONS OF LESS THAN ONE YEAR, 1950–67

Year	Number of Cases		Percentage of Table A Cases	
	Males	Females	Males	Females
1950	2,678	1,465	44.8	29.4
1951	1,498	774	33.2	19.7
1952	891	462	23.7	13.7
1953	755	319	23.0	10.9
1954	600	208	20.5	8.9
1955	609	228	22.5	10.0
1956	587	257	21.1	10.8
1957	555	192	20.2	8.6
1958	522	182	20.9	9.9
1959	564	209	25.0	12.5
1960	819	175	34.1	11.3
1961	965	234	35.3	13.6
1962	995	229	39.9	13.5
1963	1,135	225	47.9	16.9
1964	1,422	315	56.7	24.9
1965	1,734	384	61.9	30.4
1966	1,431	388	57.3	31.7
1967	1,378	354	56.6	30.3

TABLE C

CASES OF CONGENITAL SYPHILIS DEALT WITH FOR THE FIRST TIME AT THE TREATMENT CENTRES, 1950–67

Year	Under 1 year	1 and Under 5 years	5 and Under 15 years	15 years and Over	Total
1950	227	141	203	652	1,223
1951	156	89	198	684	1,127
1952	110	101	191	547	949
1953	95	77	152	520	844
1954	48	41	119	478	686
1955	41	30	114	459	644
1956	36	31	82	441	590
1957	27	26	77	427	557
1958	17	15	65	340	437
1959	20	19	29	304	372
1960	18	10	38	323	389
1961	23	4	21	292	340
1962	11	8	12	287	318
1963	16	5	16	325	362
1964	8	3	11	236	258
1965	17	5	5	248	275
1966	12	5	9	236	262
1967	15	—	5	196	216

TABLE D

DEATH RATES PER 1,000 LIVE BIRTHS, OF INFANTS UNDER 1 YEAR CERTIFIED AS DUE TO CONGENITAL SYPHILIS, 1912–67

Year	Rate	Year	Rate	Year	Rate	Year	Rate
1912	1.34	1926	0.84	1940	0.16	1954	0.003
1913	1.46	1927	0.77	1941	0.21	1955	—
1914	1.55	1928	0.71	1942	0.19	1956	—
1915	1.44	1929	0.64	1943	0.23	1957	—
1916	1.57	1930	0.55	1944	0.16	1958	0.004
1917	2.03	1931	0.45	1945	0.15	1959	0.003
1918	1.90	1932	0.42	1946	0.15	1960	—
1919	1.76	1933	0.35	1947	0.09	1961	—
1920	1.51	1934	0.30	1948	0.09	1962	0.001
1921	1.43	1935	0.26	1949	0.08	1963	—
1922	1.12	1936	0.24	1950	0.04	1964	0.001
1923	1.05	1937	0.19	1951	0.03	1965	0.001
1924	0.91	1938	0.18	1952	0.03	1966	0.001
1925	0.82	1939	0.17	1953	0.01	1967	0.001

Rates for the years 1931–49 are according to the 1940 classification (5th Revision). For 1912–30 the rates need to be multiplied by the conversion ratio 0.857 for approximate comparability.

For 1950–67 No. 020.2 in International List (7th Revision).

TABLE E

DEATHS FROM GENERAL PARALYSIS OF THE INSANE, TABES DORSALIS, AND ANEURYSM OF THE AORTA, 1911–67

Year	General Paralysis of the Insane		Tabes Dorsalis		Aneurysm of Aorta	
	Males	Females	Males	Females	Males	Females
1911–20	1,697	383	592	106	838	208
1921–30	1,204	277	632	127	860	249
1931–35	819	240	566	125	969	393
1936–39	625	227	471	106	1,017	531
1940–44	482	167	270	71	367	124
1945–49	258	101	157	41	381	130
1950–54	98	42	93	27	336	166
1955	84	36	53	24	332	173
1956	56	28	66	15	329	171
1957	48	20	53	22	358	183
1958	57	28	41	16	306	219
1959	62	27	50	22	295	190
1960	56	22	44	17	312	186
1961	37	17	41	19	286	194
1962	28	16	23	6	303	198
1963	39	10	29	16	277	209
1964	24	12	15	12	326	195
1965	23	16	24	9	354	260
1966	39	10	18	7	343	246
1967	24	2	14	13	369	266

The average for the years 1911–39 are based on the 4th Revision of the International List. Figures for the years 1940 to 1967 are according to the 7th Revision.

Non-civilian deaths are excluded from 3rd September, 1939, for males and from 1st June, 1941, for females to 31st December, 1949.

For years 1911–39—"Aneurysm of aorta" (Code 96) of the 4th Revision List based on arbitrary rules of assignment.

For years 1940 and after "Aneurysm of aorta" (Code 022) of the 7th Revision List based on assignment by the certifying medical practitioner.

TABLE F

NEW CASES OF PRIMARY AND SECONDARY SYPHILIS, OTHER EARLY SYPHILIS, AND POST-PUBERTAL GONORRHOEA PER 100,000 POPULATION, BY AGE GROUP AND SEX, HOSPITAL CLINICS, ENGLAND AND WALES

	Disease	Age Group	1966		1967	
			Male	Female	Male	Female
Syphilis	Early	All ages*	6.12	1.57	5.85	1.43
	Primary and secondary	All ages	4.84	0.98	4.56	0.99
		Under 16	0.08	0.02	0.03	0.03
		16 and 17	1.92	2.15	2.85	2.39
		18 and 19	6.91	4.36	9.33	3.45
		20–24	15.92	4.70	12.58	4.31
		25 and over	5.59	0.72	5.31	0.79
	Congenital	All ages	0.39	0.69	0.39	0.50
		Under 1 year	0.93	1.96	1.65	1.99
		1–4	0.18	0.12	—	—
		5–14	0.11	0.15	0.08	0.06
		15 and over	0.46	0.80	0.45	0.59
Gonorrhoea Post-pubertal		All ages	119.33	38.35	130.00	44.63
		Under 16	0.88	2.68	0.67	3.15
		16 and 17	71.19	118.75	82.89	154.58
		18 and 19	239.35	210.83	297.51	270.16
		20–24	482.51	207.82	526.97	222.98
		25 and over	122.55	21.39	128.58	24.57

* Primary, secondary, and latent in the first year of infection.

TABLE G

NEW CASES OF OTHER CONDITIONS PER 100,000 POPULATION, ALL AGES, BY SEX, HOSPITAL CLINICS, ENGLAND AND WALES

Other Conditions	1966		1967	
	Male	Female	Male	Female
Total	355.84	168.84	369.74	181.22
(I) Chancroid	0.34	0.01	0.27	—
(II) Lymphogranuloma venereum	0.17	0.01	0.22	0.02
(III) Granuloma inguinale	0.01	—	0.04	—
(IV) Non-gonococcal urethritis	128.82	—	135.64	—
(V) Non-gonococcal urethritis with arthritis	1.40	—	1.52	—
Total of (IV) and (V)	130.22	—	137.16	—
(VI) Late or latent Treponematoses presumed to be non-syphilitic	2.15	1.93	1.99	1.75
(VII) Other conditions requiring treatment within the Centre	96.59	101.70	107.53	114.45
(VIII) Conditions requiring no treatment within the Centre	125.74	64.60	122.01	64.27
(IX) Undiagnosed	0.62	0.59	0.56	0.73